COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

MEETING MINUTES
July 10, 2014

Meeting Location: Children's Board of Hillsborough County
1002 East Palm Avenue, Tampa, FL 33605

Commissioners Present: David Sanders (Chairman), Amy Ayoub, Cassie Statuto Bevan, Theresa Covington, Susan Dreyfus, Wade Horn, Patricia Martin, Michael Petit, Jennifer Rodriguez, David Rubin, Marilyn Zimmerman. Commissioner Bud Cramer was not in attendance.

Designated Federal Officer: Liz Oppenheim, Chief of Staff

Conduct of the Meeting: In accordance with the provisions of Public Law 92-463, the Commission to Eliminate Child Abuse and Neglect Fatalities held a meeting that was open to the public from 8:00 a.m.–4:30 p.m. at the Children's Board of Hillsborough County. The purpose of the meeting was for Commission members to gather national and state-specific information regarding child abuse and neglect fatalities. The Commission heard from researchers and issue experts regarding the scope of the problem, strategies for improving national data collection, policy barriers and opportunities to reduce maltreatment fatalities, confidentiality issues, and potential solutions. Experts from such disciplines as child welfare, law enforcement, health, and public health presented strategies for addressing the issue of child abuse and neglect fatalities.

Chairman Sanders informed participants that the agenda was very tight and that he was going to keep closely to the times allotted for each presentation. He indicated that audience members would not have the opportunity to ask questions during the proceedings and requested that audience members not engage in direct dialogue with the Commissioners. Finally, he indicated that any audience members wishing to comment may leave written testimony in the designated file at the registration table or submit testimony or written feedback through the Commission's website.

OPENING REMARKS

Chairman David Sanders

Chairman Sanders opened the meeting by thanking the Children's Board of Hillsborough County for hosting the Commission's meeting in Tampa. His opening remarks included the following:

- Eleven of 12 Commissioners and more than 200 stakeholders are present or listening by phone.
- The Commission's legislative charge includes holding hearings in jurisdictions where there are high and low fatality rates due to abuse and neglect or downward or upward trends in these fatalities. In Tampa, there appears to be a downward trend in child abuse and neglect fatalities, but there is also controversy about the actual numbers.
- In 2012, Florida had both one of the highest numbers of fatalities due to abuse and neglect as well as one of the highest rates.
- The Commission is seeking to understand what is working and what's not working in Florida. Are there effective practices and policies? How is effectiveness evaluated—that is, how do we know whether policies and practices are reducing fatalities due to abuse and neglect? Which federal policies support or hinder implementation of effective practices and policies at the state and local levels and by the tribes.

Interim Secretary Mike Carroll, Florida Department of Children and Families (DCF)

Secretary Carroll began by thanking the Commission for coming to Florida and the Children's Board for the good partner they have been. He described the major challenges Florida faces in child death cases:

- Reporting and classification of child deaths
- Targeting programs to those most at risk
- Reaching those children not involved in the child welfare system
- Overcoming confidentiality barriers

In response to Chairman Sanders' comment about some of the controversy over child abuse fatality numbers in Florida, Secretary Carroll explained that until recently Florida's death review committee only reviewed fatalities that were reported to the hotline and then verified to be as a result of abuse or neglect. However, Florida was reporting to NCANDS **all** child deaths reported to the hotline, regardless of findings. He also indicated that there is also great variation in reporting and verification of child fatalities among different jurisdictions throughout the state, especially with regard to cases involving neglect.

Florida has taken a few steps to remedy some of those issues:

- The newly created Child Fatality Website provides a weekly report on child fatalities that are reported to the hotline. The data captures all child fatalities regardless of whether the deaths are "verified" by child protection as having been caused by abuse, abandonment, or neglect based on a preponderance of the evidence. The website also provides information regarding whether the deceased child or the family of the child had contact with Florida's child welfare system, either through a child protective investigation and/or foster care or family support services. The system currently includes deaths since January. By fall, the website will have five years of prior data; by the end of the year, 10 years of prior data. The data will include some information about the circumstances of each child's death.
- Child death review committees now review all deaths called into the Florida Abuse Hotline, not just those "verified."
- Child fatality specialists are trained and engaged on a statewide basis in the decision-making around whether to verify a death report to get more cross-jurisdiction consistency.

- Florida is moving to drug testing in all neglect cases, to better understand the condition of the parent at the time of the incident.
- In June 2014, Governor Rick Scott signed Senate Bill 1666, which aims to strengthen laws and improve resources to protect children from abuse or neglect. An important component of this legislation created the Florida Institute for Child Welfare at the FSU College of Social Work.

Secretary Carroll also indicated that preventing child fatalities is bigger than one agency: More than 2/3 of families and 3/4 of children who died were unknown to child welfare authorities. It is important to see this as a public health and public safety issue. DCF is in the process of implementing Florida's safety methodology, which moves away from incident-based investigations to a full assessment of family dynamics. DCF also is shifting away from compliance-based decision-making to ensuring more behavioral change, including the use of rapid safety feedback system.

Secretary Carroll concluded by describing his belief that Florida will get better results for families as more science and data are infused into real-time case practice. This will enable DCF to focus on the highest risk cases and get better outcomes for children and families.

NATIONAL RESEARCH AND POLICY

A Population-Level Overview of Child Fatalities and Child Protective Service Involvement*: Emily Putnam-Hornstein, M.S.S.W., Ph.D.*

Dr. Putnam-Hornstein is an assistant professor at the University of Southern California School of Social Work, director of the Children's Data Network, and maintains a research appointment at the Child Welfare Indicators Project at U.C. Berkley. She presented findings from linking 6 million birth records to more than 1 million CPS records in California, allowing for more comprehensive analysis of many children (not just those known to CPS) over time. Her research has implications for understanding risk factors that contribute to child maltreatment fatalities and how data might be used in real time to identify those risk factors and help systems intervene sooner and more effectively.

The main points of her presentation include the following:

1. **The problem is large**. Rates of abuse in certain cohorts are significantly above the 5 percent of children reported in any given year. Over time, you see that 15 percent of children will have been reported (not substantiated) at some point before starting kindergarten. The risk increases as you add in other risk factors, such as children who are born to teen mothers or born without paternity established.
2. **We need to identify those at the highest risk.** After adjusting for other risk factors, a prior report to CPS, *regardless of its disposition,* was the single strongest predictor of a child's potential risk for injury death (intentional or unintentional) before age 5. Given the same risk factors, a child reported to CPS has about a 2 1/2 times greater risk of any injury death. Children with a prior CPS report had almost six times (5.8) greater risk of death from *intentional* injuries.
    - A child with a prior report of physical abuse had a risk of *intentional* injury death 5 times greater than a child reported for neglect. Children reported for neglect had a significantly higher risk of *unintentional* injury death.
    - This raises the question: Should the prevention and case management approach differ depending on the type of report (physical abuse vs. neglect)?

3. **Child welfare intervention is too limited.** Looking across all sleep death codes and previous reports, the risk of sleep death is about 3 ½ times greater when there has been a report of child abuse or neglect. Causes may include: (1) children known to CPS have unique risks due to prenatal drug exposure, (2) parents reported to CPS may have less adherence to safe sleep messages, or (3) difficulty in distinguishing accidental/inflicted sleep deaths. A first CPS report (regardless of disposition) significantly heightens the likelihood of a second.
4. **There are opportunities to be more strategic in front-end risk assessment, at every decision point.** The best way to reduce child abuse and neglect fatalities is to do better triage and provide better services to infants and young children known to CPS. We currently have insufficient tools to support decision-making.
    - Structured decision-making has been used for this purpose. However, social workers often complete such a tool *after* a decision is made or check boxes to get the result they want because they believe that their judgment is superior.
    - Predictive risk modeling may be a better option. It cannot replace clinical judgment, but it can help identify risk factors and augment and provide checks on that judgment. For example, it may change staffing decisions (e.g., have more experienced worker respond, infuse greater supervision). PRM could have applications for primary (screening, prioritizing), secondary (triage), and tertiary (tailoring services) prevention.

Learning From Death or Serious Injury Case Reviews and Using Child Welfare Administrative Data to Protect Newborns: *Richard Barth, M.S.W., Ph.D.*

Richard Barth is professor and dean at the University of Maryland School of Social Work. He has conducted extensive research to inform the design and redesign of child welfare services. Dr. Barth spoke to the Commission about two separate issues: Birth match is an opportunity to use available data in real time to identify children and families at risk by combining birth data (vital statistics) and CPS data so that target preventive/protective services can be provided. Dr. Barth also presented about preventing deaths of adopted children.

Part 1: Birth Match

The best predictions of harm occur when a child is highly vulnerable and a parent has clearly demonstrated inadequate or unsafe parenting (i.e., prior CPS finding). This is a significant portion of the child welfare population: 10 percent of infants entering foster care in Maryland in 2007 had parents who had lost a child to TPR. We have two options in these cases: (1) Do nothing and assume the existing system will identify these children, or (2) match birth records to TPR records and other indicators of high risk (birth match).

- If we match, options include:
    - Have no pre-existing expectations other than alerting child welfare to the situation.
    - Conduct visits to assess the family (this happens in Maryland—it is not a formal investigation).
    - Require a case to be opened (done in Michigan).
    - Assume the infant will be removed unless there is an administrative waiver (done for a time in New York City).
    - Add additional characteristics into the analysis to better understand the family dynamic.

- Virtually all states currently have the option to share birth records with child welfare agencies. Very few states do. Maryland, Minnesota, and Michigan currently use birth match.
- Arguments for birth match: Birth match is allowable, reasonable, and achievable. There is a precedent for responding differentially to children born to parents who have previous had TPRs (i.e., the Adoption and Safe Families Act). This could become the standard of care in the future.
- A similar process could be used with other parental risk factors, including children born to teen mothers who were themselves involved with child welfare, parents with serious offenses (e.g., sex offenders, homicide), or parents who have lost a child to guardianship. North Carolina's Maternal and Child Coordination Project used risk factors such as prematurity and low birth weight.
- The biggest challenge is to overcome our reluctance to identify "false positives."
- **Recommended action:**
    - Build on IM from CB (13-02) and OMB (M-11-02) to increase data sharing. Make sharing of birth data for research and identification purposes an expectation to receive federal funding.

Part 2: Preventing Child Abuse Deaths of Adopted Children

There are no good estimates for how often children die in foster care and adoptive homes. It probably happens less often than for maltreated children who remain at home or who are reunified, but the rate is still unacceptably high. These data need to be gathered and reported.

- These data are currently not captured by NCANDS or included in the *Child Maltreatment* reports, although similar data are (e.g., child fatalities who received family preservation services).
- Following up on adopted children is consistent with the government's responsibility to ensure long-term well-being of children who were formerly in foster care. Precedent is set in Fostering Connections for Success (P.L. 110-351).
- **Recommended actions**:
    - Revise CAPTA to require reporting on fatalities of children in or adopted from foster care.
    - Make progress toward a unified home study for foster and adoptive parents that captures known risk factors for maltreatment and filicide. Match data gathered against poor adoption outcomes.
    - Implement case reviews of serious and fatal maltreatment cases. Look at the work of Dr. Marian Brandon in the U.K. in this area. Develop and disseminate suggested state protocols.

Commissioner Discussion

Issues and questions raised by Commissioners in response to these presentations include the following:

- Comments that speak to potential recommendations:
    - Increase enforcement of the ASFA requirement to bypass reasonable efforts.

- Predictive analytics may support prioritization of services to children at greater overall risk. (In the interest of limited resources, may need to focus on actual risk rather than elevation in (relatively small overall) risk.
- Look at strengthening home visiting provisions in the Affordable Care Act, to provide this (demonstrated effective) service to more families in need.

- Comments that speak to future Commission strategies and meetings:
  - Look closely at the *effectiveness* of services provided. For example, research shows a higher risk of re-report for children whose families receive substance abuse services than those who do not. Are the services failing or are there other reasons, such as increased surveillance?
  - Could the Commission classify prevention programs by the quality of their supporting evidence, similar to the California Evidence-Based Clearinghouse?
  - Consider differences in how cases are treated (e.g., drug-addicted infants) based on demographics, including racial/ethnic disparities.
  - There are two very different purposes for linking data sources (research/evaluation and service provision). The barriers to these two forms of data sharing are different and should be addressed separately.
  - Need to pay attention to the gate-keeping function of child welfare: How long does it take to respond to hotline calls, how many are dropped, staff training, etc.
  - The child welfare system involves the whole community, not just CPS. Consider how the Commission might influence Medicaid policy to support early identification and prevention.
  - Consider what accounts for differences in decision-making around service provision, and what prompts an agency to move a child to foster care.
  - Look more closely at what accounts for the high percentage of reports among teen parents in (or recently in) foster care and what can be done to better support these parents (a kind of "captive audience").
  - Why do reports from nonmandated reports have a higher risk of being re-reported? (May relate to the quality of information provided or credibility given by CPS to these reports.)
  - Look at differences in outcomes for related (kinship) and unrelated foster and adoption homes, and between formal and informal arrangements, including guardianship.

Sharing Child Protective Information to Save Children's Lives: *Howard Davidson, J.D.*

Howard Davidson is the director of the American Bar Association's (ABA) Center on Children and the Law. He provided historical context about federal and state laws, regulations, and other practice guidance that impacts and inhibits information-sharing among systems to ensure child safety. Davidson noted that his recommendations were his own and did not reflect official policies of the American Bar Association or any other organization.

Davidson began by offering an overview of what he called "the historical pendulum" between privacy and access to information in Federal law, beginning with the Child Abuse Prevention and Treatment Act (CAPTA) in 1974. CAPTA was enacted with a clear mandate to preserve the confidentiality of all child protective services (CPS) records. Later reauthorizations of CAPTA allowed for release of some CPS information as authorized by state law. However, the language lacks specificity and clarity, and regulations have not been updated to reflect these

changes. The U.S. Department of Health and Human Services (HHS) has instead issued guidance in the form of questions and answers in the Child Welfare Policy Manual, most recently in 2012. He briefly discussed the impact of other legislation on the question of privacy vs. access.

Davidson also included in his discussion several reports (both public and privately sponsored) that evaluate CAPTA-mandated public disclosure policies and call for HHS to develop regulations and provide technical assistance to states around appropriate procedures for disclosure of information.

After offering this historical overview, Davidson provided some of his own observations on the issue, including the following:

- State policies must ensure compliance with relevant federal confidentiality laws. However, states may allow exceptions to the release of information in order to ensure the safety and well-being of the child, parents, and family or when releasing the information would jeopardize a criminal investigation or interfere with the protection of those who report.
- CPS information can be disclosed, with relevant state law, to properly constituted authorities and multidisciplinary case review teams but these terms have never been defined in regulation.
- *State Secrecy and Child Deaths in the U.S.*, a useful report produced by the Children's Advocacy Institute, grades states' fatality public disclosure policies.
- The amount of CAPTA money going to states annually is $26 million, compared to $4 to $6 billion annually for foster care and adoption services. This "underfunding of the front end" impacts states' ability to conduct appropriate assessments and investigations.
- The recent revisions to Florida statutes and practice with regard to release of information and transparency is a "good stance" to take.

He highlighted 10 key issues regarding release of CPS records and access to information related to child safety:

1. State laws should mandate feedback to persons who report suspected child abuse, including investigation results and actions taken.
2. Cross-state record sharing should be mandated, given the mobility of families involved with CPS.
3. States should consider and CAPTA may need to explicitly permit disclosure of some CPS information.
4. Explicit legal authority should exist for public release of information when a child is missing from foster care, group care, or from homes where they've been under protective supervision.
5. Immunity protections, beyond those related to reporting, should be strengthened for those serving abused and neglected children to minimize the fear of liability if information is shared.
6. States should develop standardized release of information forms that address child welfare and acknowledge HIPAA, FERPA, and substance abuse treatment records.
7. The expungement of unsubstantiated reports limits a potential child protection/safety tool.

8. Cross-reporting with police and prosecutors is critical and should be mandated by state law.
9. States need to recognize the need for sharing CPS information in the course of family team meetings.
10. The 2006 Child Protection and Safety Act contained important provisions related to criminal background screenings.

Davidson concluded his presentation with six federal-level recommendations to support effective multidisciplinary work to prevent child deaths:

1. Consolidate recommendations from all state/local child fatality and near-fatality review groups and follow up on implementation.
2. Produce model materials related to privacy and record access issues.
3. Create targeted financial support for maintaining effective state and local multidisciplinary teams, including child death review teams.
4. Link receipt of CAPTA Title II grants to review and implementation of the findings fatality review teams.
5. Grant subpoena power to CPS authorities to obtain records needed to investigate child maltreatment.
6. Ensure in CAPTA, HHS, and within state laws that there is a mandate to promptly share information among individuals and agencies engaged in work to protect children.

Commissioner Discussion

Issues and questions raised by Commissioners in response to these presentations include the following:

- Commissioners sought clarification about whether and how the law permits access to CPS information for specific groups, including legislative panels, physicians, and the media. Specific federal guidance is lacking in many of these areas; in some cases, state legislatures have the ability to clarify what is permissible or mandatory.
- There is little effective enforcement of privacy requirements at the federal level.
- Commissioners discussed what specific case information should be shared or not shared with the public when a child dies.
- There was a question about the value of open courts. They are not in violation of the law but do they protect the children and families in the court's care?
- Even though the primary client is dead in a fatality case, confidentiality rules still serve to protect others such as surviving siblings and the nonoffending parent. However, privacy concerns must be balanced against a public interest in the information.
- Davidson was asked to consider whether criminalizing disclosure of information has the unintended consequence of interfering with needed information-sharing.

FLORIDA STRATEGIES

What We Have Learned in Florida: Why Haven't We Put What We Already Know Into Action?: *Randell Alexander, M.D., Ph.D.*

Randell Alexander is the child protection team statewide medical director at the University of Florida, Jacksonville. He began his presentation by telling Commissioners that 20 years ago, he sat on a similar advisory board charged by Congress to issue a report on child fatalities. He went to the White House and presented the report—but nothing happened. He urged this Commission to do something that is actionable, relevant, and commands public attention. He further asserted that causes of death do not change over time. Child death reviews basically make the same recommendations. The problem is implementation.

He also urged the Commission to think in terms of **primary and universal prevention**. Approximately 60 percent of the child deaths occur in families that have no previous state involvement.

Dr. Alexander summarized the following lessons from child protection teams (CPTs) in Florida:

- You need a medically led team that works within the Department of health, but teams with the Department of Children and Families as a system for response to child abuse.
- Florida's CPTs cover every child in the state, as mandated by state law. They are multidisciplinary and medically directed.
- Statewide, 24 teams are available 24 hours/day, 7 days/week and employ expert physicians, social workers, psychologists, and attorneys.
- A medically trained member of a CPT reads ALL child abuse hotline reports and helps make a decision about what should be done. Mandated referral criteria include head injuries, allegations of sexual abuse, malnutrition or failure to thrive. The CPT must report its findings to CPS (and police when applicable) within 24 hours.
- CPT's receive $20 million from the state legislation to provide medical evaluations, child and family assessments, multidisciplinary staffings, coordination of services, expert court testimony, forensic interviews, and consultation and training.
- These teams see kids in real time, sometimes using telemedicine. They are often the leaders of death review committees.
- Challenges include funding, retaining/recruiting medical personnel, and maintaining a health focus.

Dr. Alexander then made the following recommendations:

- We need a change in culture: the focus should not just be on counting, but preventing fatalities.
- Suggested programs to consider: Center for Disease Prevention and Control's Essentials for Childhood and safe sleep innovations in Finland and New Zealand.
- We need to publicly monitor progress of prevention services, perhaps with an image or visual aid.
- In addition, we need health services to provide primary prevention, perhaps through the creation of a National Institute of Health on Child Abuse to help break down silos.
- Engage businesses in prevention.

Much of the follow-up discussion with Commissioners concerned clarification around how CPTs work with child protective services, child advocacy centers, and law enforcement throughout the screening and investigation process.

Additional Commissioner questions concerned the role of CPTs in *prevention* of child abuse fatalities, due process, and what happens when a parent fails to follow through with services.

Predictive Analytics: Panel Discussion

The key points from each panel member's presentation are captured below.

Interim Secretary Mike Carroll, Florida DCF

Secretary Carroll presented on a process instituted in Hillsborough County as a result of a series of nine child deaths in an eight-month period. Many of those cases had common characteristics: active CPS involvement, child under 3 years old, young parents, and the presence of substance abuse and, in many cases, domestic violence in the home. Secretary Carroll wanted something that could be implemented rapidly while caseworker turnover, training, and other longer-term issues were being addressed. Instead of doing the usual retrospective review, they created a process to triage cases and reallocate resources to the most critical cases at the most critical points in time.

One of the most important things they did was build a query system into their SACWIS system. Now they can search their database for cases with these targeted characteristics and respond to them differently. Last year, they had the first significant decline in Hillsborough County—from about 41 children who died from abuse and neglect per year to 26.

Lorita Shirley, Chief of Program Services—Florida, Eckerd Community Alternatives

When Eckerd was awarded the contract to oversee child welfare services in the Tampa Bay area two years ago, addressing child murders in families receiving protective services was their first priority.

- They conducted a review of every open dependency case in the Tampa Bay area—1,500 cases impacting more than 3,000 children. They discovered that parents were not involved in the development of safety plans, safety plans were not individually tailored, and changes within families were poorly monitored (e.g., new boyfriends in the home). Even when workers and supervisors identified what needed to be done, there was no follow through.
- Eckerd initiated a process called Rapid Safety Feedback. The first stage of the project was working with Mindshare to develop a system within SACWIS to search by criteria selected, mine thousands of cases, and identify those that met the criteria. They then reviewed the cases utilizing a safety-focused review tool with nine core questions, to hone in on the real issues facing families.
- Once a high-risk case is identified, Eckerd assigns a QA specialist to conduct an objective review. The QA specialist brings together the caseworker and the supervisor in a nonpunitive way to talk about what the safety concerns are and what they can do to address them. The QA specialist stays with the case until it terminates or the youngest child reaches age 3. The process allows them to track outcomes and follow through.
- Since Eckerd rolled out Rapid Safety Feedback in January 2013, there have been no child murders involving families receiving state services. It's not an evidence-based system, but it absolutely is a promising practice.

Greg Povolny, Mindshare Technology

Greg Povolny discussed how Mindshare operationalized predictive analytics for daily use in Florida.

- Mindshare produced a system for caseworkers to make daily decisions on their active cases.
- With access to data from the state system, certain school boards, and the Department of Juvenile Justice, Mindshare produced real-time dashboards that identify children who are at high risk for re-entering care, being re-abused, leaving with no diploma, and aging out. They are working on models right now regarding human trafficking.

Commissioner Questions and Discussion

Key points raised in discussion with Commissioners include the following:

- Secretary Carroll emphasized that the Hillsborough County project focused on bundles of multiple risk factors rather than cases with a single risk factor. Through the coaching/mentoring process, they hope to achieve transferred learning from the selected cases to the rest of their caseload.
- Eckerd brought resources to the table to get things going and is willing to do so in other states.
- Predictive analytics can be applied in states without a SACWIS system, as well.

Rick Selznick, North Highland

Rick Selznick discussed the data analysis process and findings.

- North Highland spent five weeks on the data discovery process—three weeks identifying data elements (including stakeholder interviews) and two weeks conducting the analysis.
- They focused their review on two data sources: the Florida SACWIS system and the Child Death Review Database. They conducted trend analyses regarding alleged and verified deaths, with and without a prior contact with DPFS to serve as a baseline.
- Generally, there has been a downward trend since 2010 with both alleged and verified child maltreatment deaths. Abuse, drowning, and asphyxiation deaths together accounted for approximately 50 percent of all deaths analyzed.

Albert Blackmon, SAS

Albert Blackmon went into greater detail regarding the child maltreatment fatality analysis done by SAS.

- The analysis found that prior in-home services reduced a child's risk of death by 90 percent; however, a prior removal from the home for physical abuse increased a child's risk of death 14 times. A child's physical or mental disability also increased the risk of death significantly.
- Mr. Blackmon recommended a longitudinal study regarding the relationship between the types of services being provided and children's long-term positive outcomes (e.g., high school graduation).

Secretary Mike Carroll

Secretary Carroll plans to continue to use data analytics to surveil cases differently based on their level of risk and to learn more about what services or combinations of services have the greatest positive impact. He ended with the caveat that these analyses fall apart if caseworkers have high caseloads or there aren't sufficient services to refer families to.

Commissioner Questions and Discussion

Key points raised in discussion with Commissioners include the following:

- The state is not dependent on contractors; Rapid Safety Feedback is an internal process, although they do have ongoing technical assistance as they make the shift.
- The state's title IV-E waiver has been critical in providing Florida with the flexibility to tailor programs by community. Secretary Carroll argued for even more flexibility, across all states.
- Mindshare's role is to look at the operational data in the SACWIS system and use that data to make a prediction about each case. At that point, they turn the process over to Eckerd, who applies Rapid Safety Feedback. The model can then be re-run based on the services provided to determine whether the services are having an impact on the original risk factors.
- To avoid differing definitions and interpretations of the term "verified," the Hillsborough County project based its statistical analysis on allegations rather than verified cases.
- The Florida project was specific to fatalities, but SAS also has a statistical model known as Social Network Analysis that takes a more holistic view of the child and how external factors play into the child's overall well-being.
- Once they have total access to the data, Mindshare can start producing output in about six weeks. The models are easily replicated; they just need to be populated. The cost has been between 5 and 8 cents per child, per day.
- Right now the project is using just two data sources, but they originally identified 24. Ideally, they would get MOUs with all of them and add them into the system to get a better picture.

Tribal Strategies for Addressing Child Abuse and Neglect Fatalities: What's Working and What's Not Working: *Kristi Hill, M.S.W., A.C.S.W.*

Kristi Hill works with the Family Services Department (FSD) of the Seminole Tribe in Florida. There are six Seminole tribal reservations in six counties in Florida and approximately 4,000 tribal members. She spoke about FSD's work with the state Department of Children and Families (DCF) in addressing abuse and neglect and the intersection with the federal Indian Child Welfare Act (ICWA).

- ICWA was intended to stop the government practice of placing Indian children in boarding schools or sending them to be adopted by non-Native parents.
- There was an increase in abuse and neglect reports within the tribe six or seven years ago, but they believe it was due to more education about reporting rather than an actual increase in maltreatment.

- FSD is the tribe's child welfare program. DCF calls FSD when a case is under investigation in a tribal area. The two departments conduct mutual development of safety plans and case plans.
- Safety plans have recently been strengthened to be more than a verbal agreement. The tribe has their own safety form, and parents must sign it.
- The tribe sends workers out to follow up with families; DCF does not have the staff to do that. The tribe also goes to court hearings. (There is a tribal court, but staff are still being trained to take cases.) When children are in need of out-of-home care, they are placed according to tribal placement preferences. FSD also locates placements and conducts home studies.
- FSD's child protection team is different from DCF's. The tribal team meetings bring together tribal departments along with representatives from child welfare, education, public health, and law enforcement. They staff cases.
- Their newest program is a group home, to be used as a step-down from residential treatment.
- The tribe is fortunate in that they have resources from gaming, so there are no major funding issues.
- A key issue for the tribe is communication, with a goal of avoiding duplication of services or sending mixed messages to parents.

Commissioner discussion following Hill's presentation touched on the following issues:

- There are some unique challenges for child welfare in tribal communities, including past federal policies that undermined families, significant disproportionality of tribal children in the child welfare system, and how tribal child welfare is often a "puzzle" of the Bureau of Indian Affairs social services, state child welfare programs, and tribal consortiums. In some rural areas there are few staff, as little as one social worker for 2,000,000 acres.
- All tribes are unique and have unique ways of counting and collecting data. Most of the work is still paper based. In NCANDS, only 61 percent of Native American tribes are counted.
- The Seminole tribe has seen very few fatalities, most of them accidents. But there may be cultural issues around investigation of fatalities when they occur.
- Jurisdiction (tribe vs. state) depends on whether the child lives on or off a reservation. However, because the Seminoles do not have a tribal court, DCF can come to the reservation. The tribe and state have a good relationship but no written agreement.

Confidentiality, Transparency, Accountability, and the Media: Panel Discussion

The key points from each panel member's presentation are captured below.

Rep. Gayle Harrell, Florida House of Representatives

- Extensive work has been done recently in the Florida legislature to create more transparency for the state's child welfare system.
- It is important to put the child at center to determine an appropriate balance between transparencies and confidentiality. Consider constitutional rights against the "need to know."
- Although the current hearing is about child fatalities, policy makers have to consider the full range of cases that come to CPS.
- The state established child death review teams years ago, but there was confusion about which cases were to be reviewed (e.g., verified cases only). State law now requires review of all deaths that come through the hotline.
- The state's Critical Incident Rapid Response Team provides information to authorities right away.
- The state's new website, which includes reports about reviewed fatalities, is one way to show the public that the department and providers are being held accountable.

Judge Katherine Essrig, Florida's Thirteenth Judicial Circuit

- Florida has a complicated system of care, with varied layers and bureaucracy. Total privatization of service delivery and case management has worked well.
- The state's laws have shifted from a focus on family preservation to making safety of children paramount, including more robust safety plans.
- The entire system (e.g., law enforcement, child protection team, courts, legislature) needs to be held accountable when it fails.
- Recent child abuse deaths have had the positive result of making communities and the state take a closer look at what is working and not working.
- Essrig would like to see CECANF have some kind of life beyond its current two years, with ongoing input to Congress and the President. An ongoing effort could help centralize what is currently happening in silos and advance best practices across the country.

John Jackson (Assistant General Counsel for DCF)

- Transparency overall makes DCF work better. DCF begins from a position of openness.
- DCF considers the media a partner to get word out about issues. The public has more confidence "when we get the information out there."
- Florida is well beyond CAPTA requirements for release of information.
- Transparency has a direct impact on prevention, because the public knows more what to look for.
- There is value to including the names and pictures of children who died from child abuse to raise public awareness.

Carol Marbin Miller (Miami Herald)

- Nubia Barahona was the child at the center of reforms in Florida. She died from child abuse in 2011, but her death was not verified as an abuse fatality until April 28, 2014—after the *Miami Herald* series.
- During a period of 5 or 6 years, DCF provided Florida's governor and legislature with an "artificially reduced count" of child fatalities. "You cannot fix what you will not acknowledge is broken."
- Despite the deaths, state officials and lawmakers cut budgets for needed services for children and families (e.g., drug and alcohol treatment, mental health care, domestic violence intervention).
- In 2010, Florida changed the definition of neglect. Previously, most child deaths due to drowning and unsafe sleep were verified as resulting from neglect. After the change, such deaths were only "neglect" if the parent had understanding and intent. This placed a greater burden on child abuse investigators. It also allowed for a new, "socially acceptable" standard of behavior.
- DCF transparency rules have "tightened and loosened" through the years due to a variety of factors, including redaction of records at times.
- After the *Miami Herald* series, Marbin Miller heard from the public and lawmakers who were struck by agency decisions that seemed "at odds with commonsense." CPS investigators need critical thinking skills.

Curtis Krueger (Tampa Bay Times)

- In Florida, most child welfare records are not public unless the child dies. This is not a nationwide standard.
- There can be good and bad redaction; the ability to see the file can offer incredible insight.

Commissioner Discussion

Issues and questions raised by Commissioners in response to these presentations include the following:

- The panel was asked for their thoughts about how to extend access to information among professionals so that those treating children understand which children are at greatest risk.
- There was concern expressed for the children in the child welfare system, who have intimate details of their lives kept in files and potentially disclosed (including surviving siblings), whereas protections are extended to government agencies and their workers. Are the confidentiality guidelines currently doing more to protect the workers than the children?
- Many pieces of federal legislation get in the way of sharing data (e.g., HIPPA, mental health disclosure laws). There is a need and opportunity for memorandums of understanding (MOUs) between entities (e.g., schools and CPS).
- The relationship between a child welfare agency and the media is important. However, there needs to be more clarity and specificity regarding what CAPTA allows to be released and to whom.

Florida's Strategies for Addressing Child Abuse and Neglect Fatalities—What's Working and What's Not Working: Panel Discussion (Group 1)

The key points from each panel member's presentation, as relevant to the Commission's work, are captured below.

Lisa Rivera, Department of Children and Families

- DCF reviews deaths of children who have had prior contact with DCF as well as those who have not had prior contact.
- The DCF website will help communities understand the details of deaths in their communities.
- Collaboration, coming together for the sake of a common outcome, is important.
- Planning in isolation does not work.

Christina Spudeas, Florida's Children First

- Florida's Children First is a statewide, nonprofit watchdog with a focus on child welfare. They work with state agencies and the legislature.
- Even with the positive legislation that was passed in 2014 (and it helped that the state had surplus funding), there are still gaps that include:
    - The new law fails to offer services to people other than parents, guardians, or caregivers, despite the fact that a number of fatalities are at the hands of boyfriends or visitors in the home. These individuals are only covered if they fall under the state's definition of domestic violence.
    - The new law has improved language on safety plans, but again it is limited to parents, caregivers, or legal custodians.
    - There is a lack of documentation about referrals to, and participation in, services, in unsubstantiated cases. This is information becomes important when families are re-referred.

Major Robert Bullara, Hillsborough County Sheriff's Office

- In six Florida counties, sheriffs handle child protection investigations.
- The Hillsborough County Sheriff's Office works closely with DCF and reviews all child death investigations with fatality review specialists. There was a decline in child deaths in the county from 42 in 2010 to 27 in 2013.
- They also do random investigations to provide rapid feedback on open cases.
- His office has a big preventive component, offering parents safe sleeping information and cribs, as well as education about water and firearm safety.

Dr. Celeste Philip, Florida Department of Health

- All of the department's work is built on partnerships.
- Dr. Philip reviewed results of several successful campaigns, including water safety, safe sleep, and a statewide task force on prescription drug abuse.
- We need more information on root causes: chronic disease, connection to poverty and unemployment. The department seeks partnerships with the business community around economic investment in target neighborhoods.

- They also partner with communities around Strengthening Families, an approach that builds protective factors in families.

Major Connie Shingledecker, Manatee County Sheriff's Office

- Child abuse death review teams are working. They go beyond the data to discover trends (e.g., substance abuse was revealed as a factor in both co-sleeping and drowning deaths).
- Data also revealed that many children are killed by male paramours in the home, when mothers are not home. Major Shingledecker speculated that day care might have saved some of those lives.
- What is working in Florida:
  - Implementing local initiatives (One key program, the Parr Clinic, addresses women on methadone co-sleeping. Since that program began there have been no related deaths.)
  - Statewide education initiatives
  - Statutory changes requiring deaths be called into the hotline
  - Joint investigative report with law enforcement and child protection investigators (CPIs)
- Not working
  - Lack of uniform investigations
  - Standard investigative procedures (doll reenactments, etc.)
  - Lack of training
  - Primary focus on keeping families together (e.g., family preservation vs. child safety)
  - Focus on keeping children out of foster care
  - Initial focus that is social-service oriented
  - Trends of information not being acted on

Commissioner Discussion

Issues and questions raised by Commissioners in response to these presentations include the following:

- Panelists were asked to provide information about various aspects of criminal prosecution of child abuse in Florida, including investigation protocols.
- Most counties have local coalitions looking at prevention strategies. Healthy Start is one partner that has a statewide touch, but a local approach (primary focus is on substance abuse).
- One of the challenges to public prevention strategies arises when a doctor says something and the grandma disagrees; the family trusts grandma. Trusted people in the community are more powerful than bureaucrats.
- There was a discussion about making ongoing mandatory reporting training a requirement to maintain a professional license in some fields.
- Panelists were asked to comment on differences between counties where sheriffs' offices conduct child protection investigations and those where the child welfare agency retains this responsibility. One study showed no significant differences.

- Regarding the law that requires information to be released in cases of child abuse and neglect fatalities: Why not expand the law to cover *all* child deaths from accidents and homicides? Estimates around the country are that only 50 percent of child deaths get reported as child abuse or neglect; many deaths are still missed.

Florida's Strategies for Addressing Child Abuse and Neglect Fatalities—What's Working and What's Not Working: Panel Discussion (Group 2)

The key points from each panel member's presentation, as relevant to the Commission's work, are captured below.

Holly Grissinger, Assistant State Attorney and representative for Bernie McCabe, State Attorney, Pinellas and Pasco Counties

- Grissinger has been a prosecutor in the Sixth Judicial Circuit for nearly 14 years, with 10 of those years spent prosecuting crimes against children. Her office is responsible for prosecuting criminal cases brought to her attention by law enforcement; they have a higher standard of evidence than for a frontline worker to verify a case.
- Grissinger starts a folder on every child death case in the county, even if it does not wind up being criminal. They find it is a good way to make sure the case does not slip through the cracks.
- Many of the cases involve sexual abuse, but also abusive head trauma and other physical abuse. Some are cases of discipline taken "a bit too far"; these may not go further than an initial investigation.
- There is no standardized investigation protocol, but the State Attorney's office works closely with law enforcement. Prosecutors are actively involved in cases from the beginning to ensure that they get what they need to prosecute effectively.

Ghia Kelly, Florida Coalition Against Domestic Violence

- The Florida Coalition Against Domestic Violence is the professional organization for 42 domestic violence centers throughout Florida. They provide funding, training, and technical assistance.
- The CPI project was created to address the co-occurrence of domestic violence and child maltreatment. Domestic violence is one of the most frequently reported forms of maltreatment in Florida. Child welfare workers need training and technical assistance to understand the dynamics in homes where domestic violence was present and partner effectively with survivors.
- The program co-locates a domestic violence advocate full time within the CPI unit. A pilot was launched in 2009 in seven counties; in 2011, it expanded to four additional sites. Received additional funding as of July 1 to expand to an additional 33 counties.
- Much of the advocates' work is based on the Safe and Together Model, created by David Mandel out of Connecticut.
- Data in Panama City area (Bay County) show that domestic violence removal rates declined from about 20 percent to 9 percent during the first two years of the program; this decline is attributed to the project, model, and partnerships with law enforcement and the State Attorney's office.

- The biggest challenge was funding; the six pilot projects were locally funded. The training for the Safe and Together Model is very expensive; being able to sustain the training is one critical challenge due to high turnover among CPIs and case managers. Now that the project has shown success, DCF is willing to support the program, using child welfare waiver funds.

Mary Beth Vickers, Florida Department of Health representative to the Child Abuse Death Review (CADR) Committee

- State CADR committee was created by statute in 1999 to achieve a better understanding of the cause and contributing factors of child deaths related to abuse and neglect, with the ultimate goal of eliminating those deaths.
- State CADR has 18 members: 7 representatives of state agencies and 11 appointees from the surgeon general who represent various disciplines related to children and family issues. The state also has 24 local death review committees with a similar multidisciplinary composition.
- Effective past prevention initiatives include drowning prevention, safe sleep/SUID initiatives, drug-endangered children initiatives, Who's Watching Your Child (babysitter selection).
- Recent legislation has resulted in an expansion of the child death cases that the state and local committees will be reviewing. Vickers views this as a step in the right direction.
- Next week they are having the first statewide meeting since those changes were implemented. Future strategies may include identification of specific data elements needed to assess trends in causes and contributing factors, strategies for tracking outcomes of prevention strategies, meeting with chairs of local committees to determine how the same goals can be achieved on a local level.
- The Department of Education is represented on the statewide committee. Partnerships with the school system are very important.
- The CADR committee reports to the state health department/surgeon general's office. The statute is clear that CADR is part of the department of health, but there has been some discussion about how to make the group more independent and ensure it is accountable to the public.

Miranda Phillips, statewide membership chair, Florida Youth SHINE

- Phillips is 21 years old and aged out of foster care. She shared her own experience of growing up in group homes, separated from her biological parents and her brother. These separations impact her ability to form healthy, adult relationships.
- It is important to look at these issues as factors for former foster children who are now parents.
- The CDC has found that safe, stable, and nurturing relationships are key to preventing child abuse. Those in foster care are separated from family and other important people, losing their identity, causing lifelong trauma and negative effects.
- When foster children are moved from home to home, they often have behavior or mental health problems. They are then labeled "difficult to place" and wind up in group homes as teenagers. Shift workers in group homes are not an adequate substitute for family.

- Without family relationships, how do foster youth learn to attach to others, develop a support system, or handle day-to-day family issues? How do they learn to be loving parents themselves?
- Yet many of these teens are having children at young ages. Many of the families involved in child fatalities involve one or more parents who had been in foster care.

Victoria Vangalis Zepp, Florida Coalition for Children

- Zepp grew up in foster care herself and is now a foster and adoptive parent.
- The focus of her remarks to the Commission was the need to balance human welfare and economic prosperity; DCF has a $3 billion budget.
- Agencies are working in partnership with one another in Florida. The Florida Department of Education has a curriculum based on abuse and neglect that went into effect a year ago. There is a five-agency MOU.
- She believes we need to change the conversation around this issue: Adding a discussion of the economic impact of abuse, neglect, and foster care will help people understand that this affects *all* citizens for generations.
- It is up to all of us to make change happen—the public, big business need to be at the table.
- She believes that Hillsborough County has the resources needed to help kids, just need to eliminate man-made barriers. Do that through inclusive collaboration.
- Florida has a community-based care model and the results of community involvement show in the data. Of the five largest states, kids in Florida spend the shortest amount of time in out-of-home care. It is a model to be watched.

Barbara Macelli, program director, Healthy Families Hillsborough

- Healthy Families Hillsborough is one of 35 programs within the Healthy Families Florida network. They cover 58 counties in Florida, sponsored by Ounce of Prevention Fund within DCF (statewide) and (locally) a grant from the Children's Board of Hillsborough County.
- Healthy Families Florida was created by the legislature in 1998 as a long-term child abuse and neglect prevention program. It is modeled after the evidence-based Healthy Families America.
- In Hillsborough County, 98 percent of program graduates are free of verified abuse and neglect for three years after the program ends. This is a huge success; families seen are very high risk.
- Healthy Families and Healthy Start collaborate to have staff screen families in each of the local hospitals. More than 16,000 new parents get screening and education on the leading causes of infant death (safe sleep, safe caregivers, shaken baby syndrome).

Yomika McCalpine, support worker, Healthy Families Hillsborough

- McCalpine has been a Healthy Families support worker for the past seven years, an adoptive mother, and a new appointee to the child death review committee.
- Healthy Families services begin during pregnancy or within three months of birth and can last up to five years, depending on needs. Common challenges in families include mental health, substance abuse, domestic violence, inadequate income, and lack of knowledge of child development.

- Families receive educational messages to increase protective factors so children grow up safe and nurtured. Support workers are a “second set of eyes and ears” to watch for and prevent risks.

- [Response to Commissioner question:] There are many programs in Hillsborough County that are funded by the Children’s Board and other funders. They all work together and meet on a regular basis. There also is a triage unit at the hospital that looks comprehensively at families’ needs and recommends services to meet their needs. In Florida, Healthy Start screenings are legislatively mandated to occur during the first prenatal visit. The family answers questions about a whole host of risk factors to help identify the best services for that family. The screening is oral, and participation is between 90 and 100 percent.

CLOSING REMARKS

Chairman Sanders offered his thanks to presenters for their help in connecting what’s happening in Hillsborough County to what’s happening at a national level. He also thanked attendees for being present, both in person and on the phone. The meeting adjourned at 5:00 p.m.

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.

_____
David Sanders, Chairman, Commission to Eliminate Child Abuse and Neglect Fatalities

10/6/14
Date